Therapeutic Massage Intake Form

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name _____ Date of birth _____

Address _____

State _____ City _____ Home Phone _____

Cellular Phone _____ Occupation _____

Email: _____

Have you ever received massage therapy? _____ Yes _____ No

Type of massage experienced (Swedish, Shiatsu, Deep Tissue, etc.) _____

Are you currently taking any medications? _____ Yes _____ No

If yes, please list name and reason for medications _____

_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

____arthritis
____diabetes
____blood clots
____broken/dislocated bones
____bruise easily
____cancer chronic
____pain
____constipation/diarrhea
____auto-immune condition*
____hepatitis (A, B, C, other)
____skin conditions
____stroke
____surgery
____TMJ disorder
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

____depression, panic disorder, other psych condition
diverticulitis
____headaches
____heart conditions
____back problems
____high blood pressure
____insomnia
____muscle strain/sprain
____pregnancy
____scoliosis
seizures
____whiplash
____chemical dependency (alcohol, drugs)

Is there anything else to share or needs to be detailed:

_____

Do you have any of the following today:

_____ skin rash _____ cold/flu _____ open cuts _____ severe pain

_____ anything contagious _____ injuries/bruises

Do you have any allergies to:

_____ medications _____ foods, tree nuts, etc.

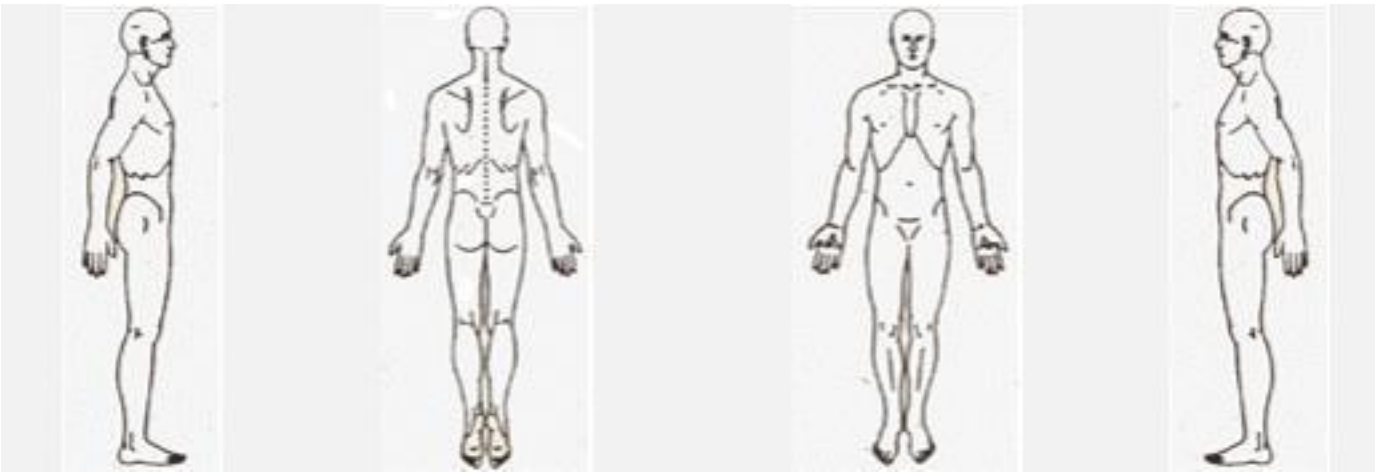
_____ skin care products

If any of the above are checked, please give details: _____

_____

Are you wearing: _____ insulin pump _____ hearing aid _____ other

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? _____

_____

_____

Please read the following information and sign below:

It is my choice to receive massage therapy. I am aware of the benefits and risks of therapeutic massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature: _____ Date _____